



MANAGEMENT OF

Vaginal Birth After Cesarean (VBAC)

2019 Update

This care process model (CPM) summarizes Intermountain Healthcare’s recommended approach for managing vaginal birth after cesarean (VBAC). The content in this CPM was developed by clinical experts from Intermountain’s Women and Newborns Clinical Program and is based on the American College of Obstetricians and Gynecologists (ACOG) *Practice Bulletin Number 184: Vaginal Birth After Cesarean Delivery* (VBAC) and the American Academy of Pediatrics (AAP) *Guidelines for Perinatal Care, 8th Edition*. This CPM is not intended to supplant the medical judgment of the provider; it will not apply to every patient situation that may arise.

► Why Focus on VBAC?

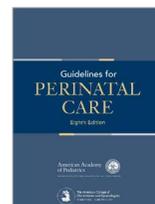
Many women desire to have VBAC. While doing so may pose certain risks, this CPM affirms that attempting a vaginal birth is a safe and appropriate choice for most women who have had a prior cesarean delivery, including some women who have had two prior low-transverse uterine incisions. The opinions of Intermountain’s experts are consistent with ACOG’s 2017 Practice Bulletin.

► GUIDELINES AND RESOURCES

Key guidelines used in this CPM

The clinical management guidelines, which form the basis of this CPM, include:

- ACOG’s *Practice Bulletin No. 184: Vaginal Birth After Cesarean Delivery*
- AAP’s *Guidelines for Perinatal Care, 8th Edition*



Resources for patient and family education

Intermountain’s resources for patient and family education include:

- *Vaginal Birth After Cesarean (VBAC)*. This fact sheet supports informed consent. Patient fact sheets (in English and Spanish) can be accessed and ordered via Intermountain’s Print Services, [Print It](#).
- *Informed Consent* acknowledgement form. This systemwide form is used for acknowledgment of procedural consent.



To find this CPM, visit:

- [Intermountain.net](#). Select “Women & Newborns” Clinical Program, then “CPMs and Guidelines,” then “Labor & Delivery.”
- [Intermountainphysician.org](#). Select “Programs & Services,” then “Clinical Programs,” then “Care Process Models (CPMs),” and locate this CPM within the “Women & Newborns” section.



► WHAT’S INSIDE?

- GUIDELINES AND RESOURCES [1](#)
- ALGORITHM: MANAGEMENT OF VBAC [2](#)

MEASUREMENTS & GOALS

The **measures** of this CPM include monitoring:

- Inclusion criteria for compliance
- Uterine rupture rates
- Prostaglandin and oxytocin use
- Time from “decision to incision” for VBACs that result in delivery by cesarean
- VBAC success rates

The **goals** of this CPM are to:

- **Summarize the roles and practices** of evidence-based VBAC management.
- **Promote resources that support this model of care**, such as ACOG guidelines, nursing protocols, patient education, and informed consent materials.

 Indicates an Intermountain measure



ALGORITHM NOTES

(a) Assessment and balance of risks.

ACOG states that “most women with one previous cesarean delivery with a low-transverse incision are candidates for and should be counseled about and offered TOLAC.” Many patients with two previous low transverse cesareans are also candidates. Multiple tools exist to assess the probability that TOLAC will be successful. Below are links to some of these tools. We encourage using these tools to help your patients make educated decisions about VBAC.

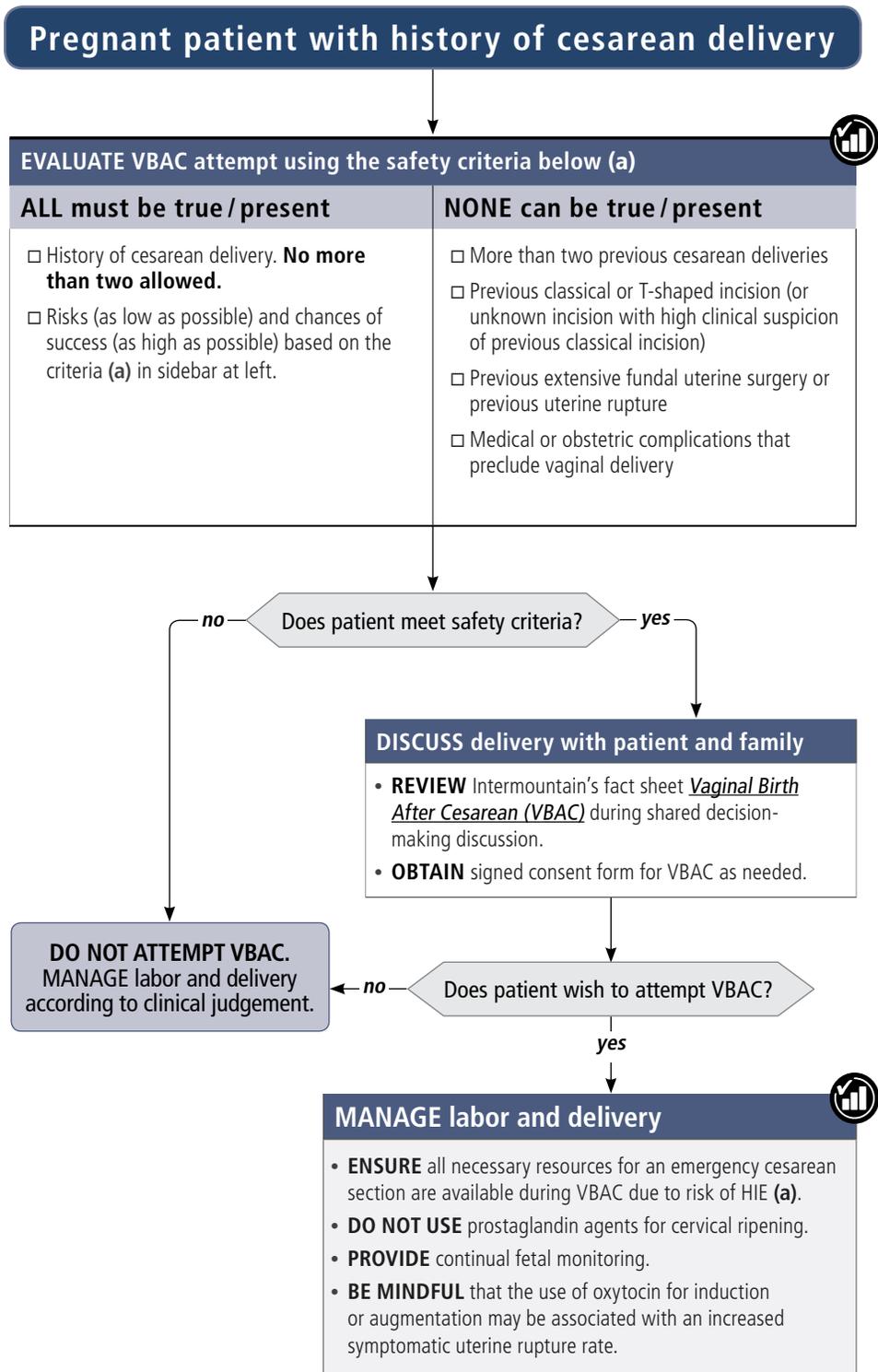
- ncbi.nlm.nih.gov/pmc/articlesPMC3008589/
- mfmunetwork.bsc.gwu.edu/PublicBSC/MFMU/VGBirthCalc/vagbirth.html

When attempting TOLAC, the risk of uterine rupture is 0.7 to 0.9%, whereas, following two cesarean sections, the risk of uterine rupture is 0.9 to 1.8%. In the event of a uterine rupture, the risk of adverse neonatal outcome is increased. Specifically, the risk of hypoxic ischemic encephalopathy (HIE) is 6.2% (95% CI 1.8 to 10.6%). HIE is associated with an increased risk of abnormal neurologic development and cerebral palsy. In addition, in the event of a uterine rupture, the risk of neonatal death is 1.8% (95% CI 0 to 4.2%).

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▶ ALGORITHM: MANAGEMENT OF VBAC



This CPM presents a model of best care based on the best available scientific evidence at the time of publication. It is not a prescription for every physician or every patient, nor does it replace clinical judgment. All statements, protocols, and recommendations herein are viewed as transitory and iterative. Although physicians are encouraged to follow the CPM to help focus on and measure quality, deviations are a means for discovering improvements in patient care and expanding the knowledge base. Send feedback to Erica Smith, MD, Intermountain Healthcare, (erica.smith@imail.org).